SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Dental	SERFF Tr Num: AEGX-125599266	State: ArkansasLH
TOI: H10I Individual Health - Dental	SERFF Status: Closed	State Tr Num: 38642
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: D491 AR	State Status: Disapproved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 10/16/2008
	Date Submitted: 04/08/2008	Disposition Status: Disapproved
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Dental	Status of Filing in Domicile:
Project Number: DN AR0041215C01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/16/2008	
State Status Changed: 10/16/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Attached for your review and approval are forms D491, D491 O.C., IGH002 and corresponding rates. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion.

Dental Policy D491 provides benefits for preventative, basic, and major dental services. The portion of covered services will increase each Policy Year (except for preventative services which will be covered at 100% as of the effective date). Basic services will be covered at 20%, 40%, and 80% for the first, second and third Policy Years (respectively). Major services will be covered at 15%, 30%, and 50% for the first, second and third Policy Years (respectively). The Policy

provides an annual maximum benefit (per insured) of $500, $750, and $1,250 for the first, second and third Policy Years (respectively). There is a $50 per year deductible per insured with a $150 maximum deductible per family.

Dental care may be obtained by Network dentists or any non-network dentist. Network dentists charge a predetermined charge (eligible expense) for dental services. Network dentists may not charge an amount that exceeds the predetermined charge. Non-network dentists may charge their prevailing charge, but benefits are based on lesser of 1) the actual charge; 2) the medium charge that half the dentists charge more and half charge less in the same geographic region; or 3) 85% of the usual and customary amount charged the same geographic region. We will pay the same coinsurance percentage of the Eligible Expense for both Network and Non-Network Dentists. There is no difference in Benefits or Deductibles between Network and non-Network Dentists.

Coverage is provided for a single adult with or without children or a married couple with or without children. There are four rate regions. Different regions of the country are assigned a rate region based on a region's prevailing charges for dental services. These products are guaranteed issue and will be mass marketed by direct response and telemarketing methods and possibly on the Internet through our website. Application IGH002 will be used to solicit this Policy.

The Policy has a Flesch Readability Score of 42.8. Microsoft Word 2003 was used to obtain these scores. Variable information is printed in red and bracketed.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print. Completed filing forms are attached.

Company and Contact

Filing Contact Information

Mat Thekkil, Contract Analyst
2700 W Plano Parkway
Plano, TX 75075

mthekkil@aegonusa.com
(972) 881-6452 [Phone]
(972) 881-4097[FAX]

Filing Company Information

Stonebridge Life Insurance Company	CoCode: 65021	State of Domicile: Vermont
29 South Main Street	Group Code: 468	Company Type:
Rutland, VT 05701-5014	Group Name:	State ID Number:

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

(410) 685-5500 ext. [Phone]

FEIN Number: 03-0164230

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	10/16/2008	10/16/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	06/13/2008	06/13/2008			
Pending Industry Response	Rosalind Minor	04/09/2008	04/09/2008			

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Time for review	Note To Filer	Rosalind Minor	10/07/2008	10/07/2008
Response to your Objection Letter dated 06-13-08	Note To Reviewer	SPI ADMSLH	08/21/2008	08/21/2008
Objection letter of 6/13/08	Note To Filer	Rosalind Minor	07/14/2008	07/14/2008
Additional Time	Reviewer Note	Rosalind Minor	08/26/2008	

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Disposition

Disposition Date: 10/16/2008
Implementation Date:
Status: Disapproved
Comment: This filing has been open for some time. As of this date, we have not received an answer to my objections; therefore, the filing is being disapproved.

If you wish to resubmit the filing at a later date, please submit it in its entirety along with the appropriate filing fee.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Product Name:	*Dental*		
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Explanation of Variables	Disapproved	Yes
Supporting Document	Health - Actuarial Justification	Disapproved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Certification/Notice	Disapproved	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT	Disapproved	Yes
Form	D491 - Individual Dental Policy	Disapproved	Yes
Form	D491 OC - Individual Dental Outline of Coverage	Disapproved	Yes
Form	IGH002 - Individual Dental Application	Disapproved	Yes
Rate	Rates - D491	Disapproved	No
Rate	Actuarial Memo - D491	Disapproved	No
Rate	AR Actuarial Exhibit C	Disapproved	No

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/13/2008
Submitted Date	06/13/2008
Respond By Date	

Dear Mat Thekkil,

This will acknowledge receipt of the captioned filing.

Objection 1

- D491 - Individual Dental Policy (Form)

Comment: Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Objection 2

- D491 - Individual Dental Policy (Form)

Comment: Please refer to the 60-day period for coverage for minors for whom the insured has filed a petition to adopt. Refer to ACA 23-79-137.

Objection 3

- D491 - Individual Dental Policy (Form)

Comment: With respect to continuation for handicapped dependents, this is to advise that there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	04/09/2008
Submitted Date	04/09/2008
Respond By Date	

Dear Mat Thekkil,

This will acknowledge receipt of the captioned filing.

Objection 1

- D491 - Individual Dental Policy (Form)
- AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT (Supporting Document)

Comment: Our Bulletin 7-2005 states that effective October 1, 2005, the Department will commence charging fees for all SERFF filings.

Please refer to our Rule and Regulation 57 for the Arkansas filing fees. If the retaliatory fee is greater than the Arkansas fee, then submit the greater fee. Please review procedures under Bulletin 7-2005. The Arkansas Fee for this submission is $50.00.

It is requested that you include our State Tracking number on the check.

A response should be sent, via SERFF, to the reviewer when the check is issued with information as to the date of the check issued along with the check number.

We will hold your filing in pending status until the fee is received.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Note To Filer

Created By:

Rosalind Minor on 10/07/2008 09:38 AM

Subject:

Additional Time for review

Comments:

Do you still need additional time for review of this filing or do you want to withdraw the filing?

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Project Name/Number:	*Dental/DN AR0041215C01*		

Note To Reviewer

Created By:

SPI ADMSLH on 08/21/2008 03:24 PM

Subject:

Response to your Objection Letter dated 06-13-08

Comments:

We would like to request additional time regarding this filing. The initial filer is no longer in our department and I have been assigned to take over this filing. Please let me know if you are able to alot more time for a response to your latest objection. Thanks!

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Note To Filer

Created By:

Rosalind Minor on 07/14/2008 10:14 AM

Subject:

Objection letter of 6/13/08

Comments:

I have not received a response to my Objection letter of 6/13/08. If you need additional time to respond, please advise.

If I do not receive a response by 8/13/08, the filing will be disapproved.

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Reviewer Note

Created By:

Rosalind Minor on 08/26/2008 10:50 AM

Subject:

Additional Time

Comments:

I will keep this submission open for 30days until September 26, 2008.

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Form Schedule

Lead Form Number: D491

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved	D491	Policy/Contract/Fraternal Certificate	D491 - Individual Dental Policy	Initial		43	D491.PDF
Disapproved	D491 OC	Other	D491 OC - Individual Dental Outline of Coverage	Initial		0	D491 OC.PDF
Disapproved	IGH002	Application/Enrollment Form	IGH002 - Individual Dental Application	Initial		0	IGH002.PDF

Stonebridge Life Insurance Company

[Home Office: Rutland, Vermont]
[Administrative Office: 2700 W. Plano Parkway, Plano, TX 75075]
[1-800-732-1821]

DENTAL INSURANCE POLICY

PRINCIPAL INSURED: **[John Doe]** POLICY NUMBER: **[12345]**

This is a dental insurance Policy. In this Policy, Stonebridge Life Insurance Company is referred to as "we," "our," or "us." The Principal Insured is "you," "your," or "yours." This Policy is a legal contract. You rely on us to honor its terms. We depend on your payment of premiums when due.

RENEWABLE AT THE OPTION OF THE COMPANY: We promise to renew this Policy as long as you pay your premium when due. We will not renew this Policy if: (1) we do not renew all other policies that are issued to everyone in your Class or in the state where it was issued; or (2) because you performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

YOUR RIGHT TO EXAMINE THE POLICY FOR 30 DAYS: You may return this Policy and cancel your coverage for any reason within 30 days of the date you receive the Policy. Any premium payment is returned. The Policy is treated as if it never existed. No benefits are paid.

TABLE OF CONTENTS

READ YOUR POLICY CAREFULLY

DENTAL INSURANCE POLICY
PREMIUMS ARE SUBJECT TO CHANGE

BENEFITS BEGIN THE FIRST YEAR OF COVERAGE

POLICY SCHEDULE

PRINCIPAL INSURED: **[John Doe]**

INSURED DEPENDENTS: **[Jane Doe]**
[All Covered Dependent Children]

POLICY EFFECTIVE DATE: **[9/30/2006]**

POLICY NUMBER: **[12345]**

INITIAL PREMIUM: **[$XX.XX]** INITIAL TERM: **[One Month]**

RENEWAL PREMIUM: **[$XX.XX]** Monthly **[$XXX.XX]** Quarterly **[$XXX.XX]** Semi-Annually **[$XXX.XX]** Annually

[POLICY BENEFITS:]

[Covered Services	Portion of Eligible Expenses Paid: 1st Year	Portion of Eligible Expenses Paid: 2nd Year	Portion of Eligible Expenses Paid: 3rd Year (and thereafter)
Preventative	100%	100%	100%
Basic	20%	40%	80%
Major	15%	30%	50%]

[POLICY MAXIMUM BENEFITS:]

	[1st Year	2nd Year	3rd Year (and thereafter)
Annual Maximum Benefit (per insured)	$500	$750	$1,250]

[POLICY DEDUCTIBLES

Annual Deductible (per Insured): $50
Annual Deductible (per Family): $150**]**

PART I: DEFINITIONS

A. "AGE" means on the Effective Date, an Insured's current age based on his last birthday. An Insured's age on the Effective Date will increase by one year on each Policy Anniversary. An Insured's age increase for purposes of this Policy will always occur on the Policy Anniversary, even if his actual birthday occurs (in most cases) during the Policy Year prior to the Policy Anniversary.

B. "CALENDAR YEAR" means a twelve month period beginning on January 1 and ending on December 31.

C. "CALENDAR YEAR DEDUCTIBLE" means the amount of Eligible Expenses that an Insured must incur each Calendar Year before benefits are payable. Any amount that you paid during the last three months of the previous year for an Insured's Eligible Expenses and which are applied to that year's Calendar Year Deductible are applied to the Insured's current year's Calendar Year Deductible

D. "CALENDAR YEAR MAXIMUM BENEFIT" means the maximum amount of benefits we pay each Calendar Year for an Insured's covered Dental Services.

E. "POLICY ANNIVERSARY" means any anniversary of the date this Policy takes effect.

F. "POLICY EFFECTIVE DATE" means the date your coverage starts. It is shown on the Policy Schedule.

G. "POLICY YEAR" means the 12 month period ending on any Policy Anniversary.

H. "CLASS" means a group of people with the same rate classification and who reside in the same state when their Policies are issued.

I. "CO-PAYMENT" means the portion of an Eligible Expense, other than a Deductible, that you are required to pay. This does not include any amount charged by a non-Network Dentist that exceeds the Eligible Expense.

J. "COVERED DEPENDENT" means any Dependent who is insured under your Policy.

K. "DENTAL DISEASE" means any malady of the teeth, the teeth-supporting bone (alveolar process), residual bony ridge without teeth, and other supporting structures including, but not limited to, infection, developmental and/or genetic anomaly and neoplasm. "Dental Disease" usually refers to caries, periodontal disease, injury, degenerative or neoplastic condition of these tissues.

L. "DENTAL PROCEDURE" means the specific procedure, treatment, device, or pharmacological regimen used by a Dentist to correct or treat a dental condition or disease.

M. "DENTAL SERVICE" means the types of dental care and treatment that are covered by this Policy and which are provided by a Dentist or under the supervision of a Dentist.

N. "DENTIST" means a person who is licensed to practice dentistry and who is operating within the scope of his license. It does not mean a member of an Insured's Immediate Family.

O. "DEPENDENT" means: (1) your lawful spouse and (2) your unmarried child(ren) who are under age 26. Child(ren) means your natural children, stepchildren, legally adopted children, or foster children.

P. "ELIGIBLE EXPENSE" means the amount that we use to base benefit payment for a covered Dental Service and Procedure.

Q. "EMERGENCY" means a dental condition or symptom resulting from Dental Disease and which arises suddenly and requires immediate care or treatment by a Dentist. Such treatment must be sought or received within twenty-four hours after the onset of the condition or symptom.

R. "IMMEDIATE FAMILY MEMBER" means your spouse, parent, child, brother or sister, or any person living with you.

S. "INSURED" means you and your Covered Dependents who are insured under this Policy.

T. "LAPSE" means the Policy coverage stops because the premium is not paid by the end of the Grace Period.

U. **"NECESSARY"** means Dental Services and supplies which are determined by us to be appropriate and:

a. necessary to meet the basic dental needs of the Insured;
b. rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Dental Service;
c. consistent in type, frequency, and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us;
d. consistent with the diagnosis of the condition;
e. required for reasons other than the convenience of an Insured or his Dentist; and
f. demonstrated through prevailing peer-reviewed medical and/or dental literature to be either: a) safe and effective for treating or diagnosing the Dental Disease or condition for which their use is proposed; or b) safe with promising efficacy for treating a life threatening Dental Disease or condition, in a clinically controlled research setting, or using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

V. **"NETWORK"** means a group of Dentists who are subject to the participation agreement in effect with us or through another entity to provide Dental Services to persons who are covered under the Policy.

W. **"PRINCIPAL INSURED"** means only the person who applied for coverage and who is named as the "Principal Insured" on the Policy Schedule.

PART II: WHEN THE COVERAGE STARTS AND STOPS

A. WHEN COVERAGE STARTS

Before this coverage takes effect: (1) you must apply; and (2) we must receive your first premium **[**before**]** **[**within 21 days of**]** the Policy Effective Date. Your coverage then starts at 12:01 AM, Standard Time, at your home on the Policy Effective Date. If these two things do not happen, your Policy is void from the start. No benefits are paid for any loss.

NOTE: If you cancel or Lapse this Policy, we can reject any new enrollment form or application that you submit for any dental insurance plan that is offered by us. We can reject any such enrollment form or application for a period of one year following the date of cancellation or Lapse.

ADDING A DEPENDENT: In order to cover any eligible Dependent not insured on the Effective Date, you must submit an Application. Before the Dependent's coverage takes effect, two things must happen: (1) we must receive your Application for the Dependent; and (2) you pay any required additional premium. The Effective Date of coverage for the additional Dependent shall be the date shown on our endorsement indicating such addition.

NEWBORN AND ADOPTED CHILDREN: Any child born to an Insured is covered from the moment of birth. Any adopted child of an Insured is covered from the moment of adoption.

A newborn or adopted child is a Covered Dependent for 31 days. Coverage then stops unless you:

a. send us a written request to continue coverage; and
b. pay the extra premium, if any.

No extra premium is due when at least one child is already insured under your Policy.

B. WHEN COVERAGE STOPS

Coverage under this Policy stops on the earliest of:

1. the date all policies that were issued to everyone in your Class are not renewed by us (You will be notified 60 days in advance of the date that your Policy is not being renewed).
2. the date the 31 day Grace Period ends if you fail to pay the premium when due (NOTE: If payment is made by credit card or automated account deductions, you must notify us in writing to cancel this insurance. See the "Payment Cancellation" provision.);
3. the date we receive your written request to cancel. (**Note Concerning Cancellation:** The provision entitled "Your Right To Examine The Policy For 30 Days" explains the rules for cancellation when your coverage is first issued. After that period the "Cancellation" provision applies.); or
4. the date we specify that your Policy stops because we determine that you performed an act or practice that constitutes fraud or material misrepresentation regarding: (1) an Insured's eligibility for coverage due to state of residence or status as a Dependent; or (2) any claim submitted for Dental Services.

A Covered Dependent's coverage also stops if the following happens:

1. **Covered Dependent Spouse:** A Covered Dependent spouse's coverage also stops on the premium due date after a change in marital status. If this happens, the Covered Dependent spouse may apply for a Policy with similar benefits. We must receive a written request within 60 days of the change in marital status. The spouse then pays the premium for a single adult at his age.
2. **Covered Dependent Child:** A Covered Dependent child's coverage also stops when the child: (1) marries or (2) turns age 26

   If one of these happens, the Covered Dependent child may apply for his own Policy with similar benefits. We must receive a written request within 60 days of when coverage stops. The child then pays the premium for a single adult.

   EXCEPTION: At age 26, a Covered Dependent child's coverage may continue under this Policy if the child is incapable of self support due to a mental or physical handicap. We must receive your written request within 60 days prior to the child attaining age 26. The premium charged is that of a single adult.

D. PRINCIPAL INSURED'S DEATH

If you die while your Policy is in force, your Covered Dependent Spouse, if any, becomes the Principal Insured. We must receive notice of your death. His premium rate will be that of a Principal Insured based on his Age and Class at the time this Policy is issued.

E. EXTENDED COVERAGE

A conditional thirty day extension of coverage takes effect if an Insured’s coverage under the Policy stops for any reason except if you cancel the Policy. It stops on the end of the thirty day period or, if earlier, the day the Insured becomes covered under a new policy or contract that provides coverage for similar Dental Services. The extension applies to the following:

1. Dental Services or Procedures that were recommended and begun prior to the date coverage stops;
2. an appliance or a modification to an appliance for which an impression was taken prior to the date coverage stops; or
3. a crown, bridge, or gold restoration for which the tooth was prepared prior to the date coverage stops.

PART III: WHAT BENEFITS WE PAY

This Policy pays benefits for covered Preventative, Basic, and Major Dental Services. The Dental Services are listed in the section titled "Covered Dental Services." To be eligible for payment, Dental Services must be received while the Insured's coverage under this Policy is in force. All Dental Services must be Necessary and provided by or under the direction of a Dentist. Dental Services may be provided by a Network Dentist or a non-Network Dentist.

The benefit amount that we pay for a covered Dental Service is based on the Dental Service's Eligible Expense. Different criteria are used to determine the Eligible Expenses for Dental Services provided by Network Dentists and those provided by non-Network Dentists.

Dental Services Provided by Network Dentists: An Eligible Expense for a Dental Service is the amount that Network Dentists are contractually obligated to charge everyone who is insured under the Policy. Network Dentists are not permitted to charge an Insured more than the Eligible Expense.

Dental Services Provided by non-Network Dentists: An Eligible Expense for a Dental Service is the smaller of (1) the amount a Dentist charges an Insured; (2) the Medium Charge; or (3) 85% of the usual and customary charge for the geographical region where the Dental Service is received. A Medium Charge is the amount that half the Dentists in a geographical region charge more and half charge less for the same Dental Service. No benefits are payable for any portion of a Dentist's charge that exceeds an Eligible Expense. (Example: If we determine that the Medium Charge in your geographic region is $100.00 and your Dentist charges $125.00, we consider $100.00 to be the Eligible Expense. If, however, 85% of the usual and customary charge equals $95.00, then we consider $95.00 to be the Eligible Expense. If your Dentist charges $75.00, we consider $75.00 to be the Eligible Expense.)

We pay the same percentage of an Eligible Expense when a covered Dental Service is provided by a Network or non-Network Dentist. The percentages that we pay for Preventative, Basic, and Major Dental Services are shown on the Policy Schedule. You are responsible for paying the difference between the benefit amount that we pay and the Eligible Expense. This difference is the Co-Payment. You are also responsible for paying any amounts charged by a non-Network Dentist that exceed an Eligible Expense.

Calendar Year Deductible: No benefits are paid in a Calendar Year for Basic and Major Dental Services until the Insured's Calendar Year Deductible is satisfied. The Calendar Year Deductible is shown on the Policy Schedule. There is no deductible for Preventative Dental Services.

Calendar Year Maximum Benefit: A Calendar Year Maximum Benefit applies to each Insured. It is shown on the Policy Schedule. It is the total amount of benefits that we pay in a Calendar Year for each Insured. You are responsible for any charges for Dental Services that an Insured receives after he has met his Calendar Year Maximum Benefit.

Alternative Procedures: If two or more Dental Procedures are adequate and appropriate treatment to correct a condition, the benefit payment is based on the Eligible Expense for the least expensive Dental Procedure. We can request an Insured's dental x-rays and records to help us determine which Dental Procedure we will consider for payment. If we do not receive the x-rays or records, we will decide which Dental Procedure is adequate and appropriate treatment to correct the condition. We will make adjustments that we deem proper if we later receive the x-rays and records and determine that a different Dental Procedure is more appropriate.

Pre-Treatment Estimate: You should request from us a pre-treatment estimate if the charges for a recommended Dental Service(s) exceeds $300.00. We must receive the Dentist's treatment plan that includes a description of the condition, the Dental Service(s) and the Dental Procedure(s) to be performed, and any supporting x-rays. We will inform you and the Dentist what Dental Service(s) and Procedure(s) that we cover and their Eligible Expense. If you do not request a pre-treatment estimate, we will determine the Dental Service(s) and Procedure(s), if any, that we cover when we review the claim for payment.

COVERED DENTAL SERVICES

Preventative Dental Services

1. Oral Examinations: Covered as a separate benefit only if no other Dental Service was done during the visit other than radiographs (x-rays). Limited to two times per Calendar Year, but only one time every six months.

2. Dental Prophylaxis (cleaning): Limited to two times per Calendar Year, but only one time every six months.

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3. Diagnostic Casts: Limited to one time during a twenty-four month period.

4. Fluoride Treatments: Limited to Insureds who are under the Age of 16 years and once per six month period. Treatment must occur in conjunction with a Dental Prophylaxis.

5. Radiographs (x-rays)

Bite-Wing Radiographs: Limited to one series of films per Calendar Year.

Complete Series or Panorex Radiographs: Limited to one time during a thirty-six month period.

Extraoral Radiographs: Limited to two films per Calendar Year.

Individual Periapical Radiographs

Occlusal Radiographs

6. Sealants: Limited to Insureds who are under the Age of 16 years and once per first or second permanent molar every five years.

Basic Dental Services

1. Adjunctive Services

Analgesia

Desensitizing Medicament

General Anesthesia: Covered only if required for Insureds who are under the Age of 6 years or Insureds who have behavioral problems or physical disabilities.

Intravenous Sedation and Analgesia

Occlusal Adjustment

Occlusal Guards: Limited to one guard during a five year period

Palliative Treatment: Covered only if no other Dental Service other than examination and radiographs were done during the visit.

2. Minor Restorative Services

Amalgam Restorations: Multiple restorations on one surface will be treated as a single filling.

Space Maintainers: Limited to Insureds who are under the Age of 16 years and only one time during their lifetime. Benefit includes all adjustments within the six month period after installation.

Provisional Splinting

Composite Resin Restorations

Pin Retention: Limited to two pins per tooth.

3. Endodontics

Apexification

Apicoectomy and Retrograde Filling

Hemisection

Root Canal Therapy

Root Resection

Therapeutic Pulpotomy

4. Oral Surgery

Alveoloplasty

Biopsy

Frenectomy

Incision and Drainage

Removal of a Benign Cyst

Removal of Exostosis

Root Recovery

Root Removal

Simple Extraction

Surgical Extraction of Erupted Teeth and Roots

Surgical Extraction of Impacted Teeth

5. Periodontics

Crown Lengthening*

Gingivectomy*

Osseous Graft*

Osseous Surgery*

Soft Tissue Surgery*

Periodontal Maintenance: Limited to two times during the twelve month period following active and adjunctive periodontal therapy exclusive of gross debridement.

Provisional Splinting

Scaling and Root Planing: Limited to one time per quadrant during a twenty-four month period.

***** Only one of these Dental Services is covered per quadrant during a thirty-six month period.

Major Dental Services

1. Crowns: Limited to one crown per tooth during a 5 year period and only when a filling cannot restore the tooth.

2. Fixed Bridges

3. Full Dentures: No additional allowances for over-dentures or customized dentures.

4. Gold Inlays and Onlays: Limited to one time during a five year period and only where amalgam (silver) fillings cannot restore the tooth.

5. Partial Dentures: No additional allowances for precision or semi-precision attachments.

6. Porcelain Onlays

7. Post and Cores: Covered only for teeth that have had root canal therapy.

8. Relining Dentures: Limited to relinings done more than six months after the original insertions. Only one relining per Calendar Year.

9. Re-Cement Bridges, Crowns, and Inlays

10. Repairs to Dentures and Bridges: Limited to repairs or adjustments done within twelve months after the original insertion.

11. Sedative Fillings: Covered as a separate benefit only if no other Dental Services other than examination and radiographs were done during the Visit.

PART IV: EXCLUSIONS

We will not pay any benefits for any of the following:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Service or procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.).
4. Reconstructive surgery regardless of whether or not the surgery is incidental to a Dental Disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Service not directly associated with a Dental Disease or condition.
6. Any Dental Procedure not performed in a dental office, medical facility, or a similar facility whose primary function is to perform Dental Procedures.
7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. This also includes any experimental, investigational or unproven procedure that is the only available treatment for a particular condition if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Dental Services for injuries or conditions covered by Worker's Compensation or employer liability laws, or which are provided without cost to the Insured by any municipality, county, or other political subdivision. This exclusion does not apply to any Dental Services covered by Medicaid or Medicare.
9. Expenses for Dental Services begun prior to the date the Insured's coverage under the Policy starts.
10. Dental Services received after the date an Insured's coverage under the Policy stops, including Dental Services for dental conditions arising prior to the date the insured's coverage stops. This does not apply to any Dental Services that are covered under the Extended Coverage provision.
11. Dental Services provided in a foreign country, unless required as an Emergency.
12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of natural teeth lost prior to the date the Insured's coverage starts may not occur until twelve months after coverage has been in force for 12 continuous months.
14. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.

15. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
16. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
17. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
18. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
19. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
20. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because the Insured did not follow instructions on proper use and care, the Insured is liable for the cost of replacement.
21. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months after the insertion of a prosthesis. After the six month waiting period, relines are covered not more than once every 12 months.
22. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
23. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
24. Procedures related to the reconstruction of an Insured's correct vertical dimension of occlusion (VDO).
25. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
26. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
27. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
28. Treatment of malignant or benign neoplasms, cysts, or other pathology, unless removed through an excision. Treatment of congenital malformations of hard or soft tissue, including excision.
29. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
30. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
31. Acupuncture; acupressure and other forms of alternative treatment.
32. General Anesthesia, except if required for Insureds under 6 years of age or Insureds with behavioral problems or physical disabilities.
33. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
34. Occlusal guards except if prescribed to control habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
35. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

PART V: HOW TO FILE A CLAIM

A. NOTICE OF CLAIM: The Dentist may submit your claim. If not, you must notify us within 60 days after a covered loss occurs or starts, or as soon as possible. Notice is sent to the plan administrator. You should always include your name, the name of the Insured who received the Dental Services and Procedures, and your Policy Number.

B. CLAIM FORMS: Claim forms are used for filing Proof of Loss. They are sent to the person who is making the claim. If such forms are not furnished before the expiration of fifteen (15) days after the insurer receives notice of any claim under this Policy, the person making such claim shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. The statement should be sent within the time noted for Proof of Loss.

C. PROOF OF LOSS: Written proof of loss must be provided within 90 days after the date of loss. If it is not reasonably possible to furnish the necessary proof within the 90 days, a claim will not be reduced or denied because of failure to do so.

D. GRIEVANCE PROCEDURE: If you would like to file a complaint over a claim or would like information about our grievance procedures, please contact the plan administrator using the phone number on the back of your ID card or by writing to:

[Dental Grievances
P.O. Box 30569
Sandy, UT 84070]

PART VI: HOW WE PAY CLAIMS

A. PAYMENT OF CLAIMS: Payment is made immediately after we receive written Proof of Loss. All benefits are paid to the person making the claim. Any benefits unpaid at your death are paid to your estate.

B. TIME OF PAYMENT OF CLAIM: We will pay benefits as soon as the claimant files written Proof of Loss.

C. EXAMINATION OF DENTAL OR PHYSICIAN RECORDS: We may, at our expense, examine an Insured's Dental and Physician records as often as reasonably necessary while a claim is pending.

PART VII: OTHER IMPORTANT INFORMATION

A. LEGAL ACTIONS: You may not bring a lawsuit against us (e.g., if we do not pay a claim): (1) during the 60 days after we receive written notice of loss; or (2) after 3 years from the time written proof of loss is required.

B. PRONOUNS: Masculine pronouns also refer to the feminine gender unless stated otherwise.

C. MISSTATEMENT OF AGE: If an Insured's Age is misstated, premiums are changed to what they should be for the Insured's correct age.

D. CANCELLATION: You may cancel this Policy by delivering or mailing written notice to us. You must specify the effective date of your cancellation. We may delay the date you request until your next monthly premium due date. Any unused premium is prorated from the date of cancellation and refunded to you. If you do not specify a date, your cancellation is effective on your next premium due date.

Cancellation is without prejudice to any claim originating prior to the date of cancellation.

E. ENTIRE CONTRACT: This Policy and any endorsements or attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

F. RIGHT TO RECOVERY: Within 12 months of payment, we have the right to recover any benefit payment, in whole or in part, that we paid in error. We will recover the amount we paid in error from the person, Dentist, or Dental Practice that we originally paid the claim

G. REFUND OF UNEARNED PREMIUM: If an Insured dies, any premium that is paid for his coverage beyond the end of the month in which his death occurs is refunded. The refund is paid within 30 days after we receive proof of the Insured's death.

H. INCONTESTABILITY: The validity of a Policy may be contested during the first 24 months of coverage if you fail to give to the best of your knowledge and belief, true and complete answers in your Application. The validity of the Policy may not be contested after it has been in force during the your lifetime for 24 months, except for fraudulent misstatements in his Application, you perform an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage, or non-payment of premiums when due.

I. CONFORMITY WITH STATE STATUTES: The provisions of this Policy must conform with the laws of the state in which you reside on the Effective Date. If any do not, they are hereby amended to conform.

J. GRACE PERIOD: You have a grace period of 31 days after the due date to pay each renewal premium. The coverage stays in force if the premium is paid during this grace period. If the premium is not paid within this Grace Period, your Policy will Lapse.

K. RIGHT TO ADJUST PREMIUMS: We may change our Table of Premium Rates. Any change made to your premium will be made on a uniform basis to all insureds in your Class. Class is defined as a group of people with the same rate classification and who resided in the same state when their Policy is issued. We will not increase your rates in the first 12 months of coverage. After that, we will not increase your rates more than once in any 12 month period. We will send to you a notice at least 60 days prior to any rate increase.

L. UNPAID PREMIUM: Any premium due and unpaid may be deducted from a claim payment.

[PART VIII: HOW YOU PAY YOUR PREMIUM

A. PREMIUM PAYMENTS: You keep coverage in force by paying the premiums. Your first premium is due as stated in the "When Coverage Starts" provision. After that, premiums are due on the first day of each renewal period. Three payment methods are available: (1) we can bill you directly; (2) you can pay by credit card; or (3) you can pay by automatic deductions from your bank checking or savings account. The Renewal Premium modes are shown on your Policy Schedule. (NOTE: Credit Card Payment is not permitted in some states.)

1. **We Bill You:** Premiums can be paid in advance by using any of the premium modes shown in the Policy Schedule. All premiums are payable to our Administrative Office.

2. **You Pay By Credit Card:** If credit card payment is used, our receiving your credit card billing authorization is treated as payment. The credit card company assumes the duty to pay each premium when due. You are billed by them through the credit card. Premiums are paid for as long as you authorize payment and your credit card remains in effect. This is subject to the option of the credit card company not to make payment if your credit card account is over limit or past due. We will bill you directly if payment is not made by the credit card company.

3. **You Pay By Automatic Bank Account:** If bank account payment is used, our receiving your authorization to deduct premiums from your bank account is treated as payment. The bank pays each premium when due. Premiums are paid for as long as you authorize payment, provided there are enough funds in your bank account to pay the premium. We will bill you directly if payment cannot be automatically deducted from your bank account.

B. PAYMENT CANCELLATION: If you choose to cancel credit card or bank account payments, you must notify us in writing. We will stop your billing. You must pay for any coverage prior to our receiving your notice. If you wish to continue coverage, we will bill you directly.]

IN WITNESS, this Policy is signed by our President and Secretary.

Marilyn Carp
President

Craig D. Vermie
Secretary

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: 2700 W. Plano Pkwy, Plano, TX 75075
1-800-732-1821

REQUIRED OUTLINE OF COVERAGE

DENTAL POLICY D491

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Stonebridge Life Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

RENEWABLE AT THE OPTION OF THE COMPANY: We promise to renew this Policy as long as: (1) you pay your premium when due. We will not renew this Policy if: (1) we do not renew it and all other policies that are issued to everyone in your Class or in the state where it was issued; or (2) we do not renew it because you performed an act or practice that constitutes fraud or material misrepresentation regarding a claim for benefits or eligibility for coverage.

YOUR RIGHT TO EXAMINE THE POLICY FOR 30 DAYS: You may return this Policy and cancel your coverage for any reason within 30 days of the date you receive the Policy. Any premium payment is returned. The Policy is treated as if it never existed. No benefits are paid.

DENTAL COVERAGE. This category of coverage is designed to provide insured persons with dental benefits, subject to any limitations contained in the Policy.

BENEFITS

This Coverage pays benefits for covered Preventative, Basic, and Major Dental Services as detailed in the policy. To be eligible for payment, Dental Services must be received while the Insured's coverage under this Policy is in force. All Dental Services must be Necessary and provided by or under the direction of a Dentist. Dental Services may be provided by a Network Dentist or a non-Network Dentist as defined in the policy.

The benefit amount that we pay for a covered Dental Service is based on the Dental Service's Eligible Expense. Different criteria are used to determine the Eligible Expenses for Dental Services provided by Network Dentists and those provided by non-Network Dentists.

We pay the same percentage of an Eligible Expense when a covered Dental Service is provided by a Network or non-Network Dentist. The percentages that we pay for Preventative, Basic, and Major Dental Services are shown on the Policy Schedule. You are responsible for paying the difference between the benefit amount that we pay and the Eligible Expense. This difference is the Co-Payment. You are also responsible for paying any amounts charged by a non-Network Dentist that exceed an Eligible Expense.

Calendar Year Deductible: No benefits are paid in a Calendar Year for Basic and Major Dental Services until the Insured's Calendar Year Deductible is satisfied. The Calendar Year Deductible is shown on the Policy Schedule. There is no deductible for Preventative Dental Services.

Calendar Year Maximum Benefit: A Calendar Year Maximum Benefit applies to each Insured. It is shown on the Policy Schedule. It is the total amount of benefits that we pay in a Calendar Year for each Insured. You are responsible for any charges for Dental Services that an Insured receives after he has met his Calendar Year Maximum Benefit.

COVERED DENTAL SERVICES

Preventative Dental Services

1. Oral Examinations: Covered as a separate benefit only if no other Dental Service was done during the visit other than radiographs (x-rays). Limited to two times per Calendar Year, but only one time every six months.

2. Dental Prophylaxis (cleaning): Limited to two times per Calendar Year, but only one time every six months.

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3. Diagnostic Casts: Limited to one time during a twenty-four month period.

4. Fluoride Treatments: Limited to Insureds who are under the Age of 16 years and once per six month period. Treatment must occur in conjunction with a Dental Prophylaxis.

5. Radiographs (x-rays)

Bite-Wing Radiographs: Limited to one series of films per Calendar Year.

Complete Series or Panorex Radiographs: Limited to one time during a thirty-six month period.

Extraoral Radiographs: Limited to two films per Calendar Year.

Individual Periapical Radiographs

Occlusal Radiographs

6. Sealants: Limited to Insureds who are under the Age of 16 years and once per first or second permanent molar every five years.

Basic Dental Services

1. Adjunctive Services

Analgesia

Desensitizing Medicament

General Anesthesia: Covered only if required for Insureds who are under the Age of 6 years or Insureds who have behavioral problems or physical disabilities.

Intravenous Sedation and Analgesia

Occlusal Adjustment

Occlusal Guards: Limited to one guard during a five year period

Palliative Treatment: Covered only if no other Dental Service other than examination and radiographs were done during the visit.

2. Minor Restorative Services

Amalgam Restorations: Multiple restorations on one surface will be treated as a single filling.

Space Maintainers: Limited to Insureds who are under the Age of 16 years and only one time during their lifetime. Benefit includes all adjustments within the six month period after installation.

Provisional Splinting

Composite Resin Restorations

Pin Retention: Limited to two pins per tooth.

3. Endodontics

Apexification

Apicoectomy and Retrograde Filling

Hemisection

Root Canal Therapy

Root Resection

Therapeutic Pulpotomy

4. Oral Surgery

Alveoloplasty

Biopsy

Frenectomy

Incision and Drainage

Removal of a Benign Cyst

Removal of Exostosis

Root Recovery

Root Removal

Simple Extraction

Surgical Extraction of Erupted Teeth and Roots

Surgical Extraction of Impacted Teeth

5. Periodontics

Crown Lengthening*

Gingivectomy*

Osseous Graft*

Osseous Surgery*

Soft Tissue Surgery*

Periodontal Maintenance: Limited to two times during the twelve month period following active and adjunctive periodontal therapy exclusive of gross debridement.

Provisional Splinting

Scaling and Root Planing: Limited to one time per quadrant during a twenty-four month period.

***** Only one of these Dental Services is covered per quadrant during a thirty-six month period.

Major Dental Services

1. Crowns: Limited to one crown per tooth during a 5 year period and only when a filling cannot restore the tooth.

2. Fixed Bridges

3. Full Dentures: No additional allowances for over-dentures or customized dentures.

4. Gold Inlays and Onlays: Limited to one time during a five year period and only where amalgam (silver) fillings cannot restore the tooth.

5. Partial Dentures: No additional allowances for precision or semi-precision attachments.

6. Porcelain Onlays

7. Post and Cores: Covered only for teeth that have had root canal therapy.

8. Relining Dentures: Limited to relinings done more than six months after the original insertions. Only one relining per Calendar Year.

9. Re-Cement Bridges, Crowns, and Inlays

10. Repairs to Dentures and Bridges: Limited to repairs or adjustments done within twelve months after the original insertion.

11. Sedative Fillings: Covered as a separate benefit only if no other Dental Services other than examination and radiographs were done during the Visit.

PART IV: EXCLUSIONS

We will not pay any benefits for any of the following:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Service or procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.).
4. Reconstructive surgery regardless of whether or not the surgery is incidental to a Dental Disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Service not directly associated with a Dental Disease or condition.
6. Any Dental Procedure not performed in a dental office, medical facility, or a similar facility whose primary function is to perform Dental Procedures.
7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. This also includes any experimental, investigational or unproven procedure that is the only available treatment for a particular condition if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Dental Services for injuries or conditions covered by Worker's Compensation or employer liability laws, or which are provided without cost to the Insured by any municipality, county, or other political subdivision. This exclusion does not apply to any Dental Services covered by Medicaid or Medicare.
9. Expenses for Dental Services begun prior to the date the Insured's coverage under the Policy starts.
10. Dental Services received after the date an Insured's coverage under the Policy stops, including Dental Services for dental conditions arising prior to the date the insured's coverage stops. This does not apply to any Dental Services that are covered under the Extended Coverage provision.
11. Dental Services provided in a foreign country, unless required as an Emergency.

12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of natural teeth lost prior to the date the Insured's coverage starts may not occur until twelve months after coverage has been in force for 12 continuous months.
14. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
15. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
16. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
17. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
18. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
19. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
20. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because the Insured did not follow instructions on proper use and care, the Insured is liable for the cost of replacement.
21. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months after the insertion of a prosthesis. After the six month waiting period, relines are covered not more than once every 12 months.
22. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
23. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
24. Procedures related to the reconstruction of an Insured's correct vertical dimension of occlusion (VDO).
25. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
26. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
27. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
28. Treatment of malignant or benign neoplasms, cysts, or other pathology, unless removed through an excision. Treatment of congenital malformations of hard or soft tissue, including excision.
29. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
30. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
31. Acupuncture; acupressure and other forms of alternative treatment.
32. General Anesthesia, except if required for Insureds under 6 years of age or Insureds with behavioral problems or physical disabilities.
33. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

34. Occlusal guards except if prescribed to control habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
35. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

DENTAL APPLICATION

[Check the coverage plan you want: o Low Coverage o Medium Coverage o High Coverage]
[I want coverage for o Me only o Me and Spouse o Me and Children o Me and Family]

[(Please Print)
Your Name o Mr. o Mrs. o Miss _____
First Middle Initial Last
Address _____
Street or RD #
City _____ State _____ Zip _____

Your Date of Birth _____ Age _____ Male o Female o Phone # (_____)_____
Month Day Year Area Code

Spouse's Name (if to be insured) _____
First Middle Initial Last

Spouse's Date of Birth _____ Age _____ Male o Female o Phone # (_____)_____
Month Day Year Area Code

Child's Name (if to be insured) _____
First Middle Initial Last

Child's Date of Birth _____ Age _____ Male o Female o Phone # (_____)_____]
Month Day Year Area Code

[(To cover additional children, please include their information on a separate sheet of paper.)]

[PAYMENT INFORMATION [(Select how you want to pay, from a, b, or c)]

(a) o Bill me directly. I have enclosed my first month's premium.

(b) o Deduct from my Bank/Credit Union checking Account (Your payment is made directly through your bank or credit union share draft account.) IMPORTANT: Write "VOID" on a blank check from this account and send it with this application.

(c) o Charge my Credit Card (check one): o Visa o Master Card o Discover (Your payments are automatically billed to your credit card account and shown as part of your statement.)

Account # _____Expiration Date _____

Subject to my accounts' rules, charge or deduct my premiums (including future changes to my insurance) by electronic or other method from the credit card or checking account I have selected above. I can cancel this payment method at any time by writing to you.]

I would like to apply for the [Stonebridge Life Insurance Company's Dental Insurance Plan]. I understand that coverage begins on the policy effective date as shown on my Policy Schedule and Stonebridge Life receives my first premium payment **[**prior to/within 21 days after the effective date**]**. **[**I have read my state's fraud statement on the back of this application**]**.

[Your] Signature (required) X _____ Date _____

[Spouse Signature (if to be insured) X _____ Date _____]

Stonebridge Life Insurance Company
[Home Office: Rutland, Vermont]
[Administrative Office: 2700 W. Plano Parkway, Plano, TX 75075]

[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Residents of DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Residents of LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Residents of MAINE, TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Residents of NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Residents of PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**]**

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

Supporting Document Schedules

Satisfied -Name: Explanation of Variables

Review Status: Disapproved 10/16/2008

Comments:
Explanation of Variables

Attachment:
Explanation of Variables.PDF

Satisfied -Name: Health - Actuarial Justification

Review Status: Disapproved 10/16/2008

Comments:
Attached to Rate Schedule.

Satisfied -Name: Outline of Coverage

Review Status: Disapproved 10/16/2008

Comments:
Attached to Form Schedule

Satisfied -Name: Application

Review Status: Disapproved 10/16/2008

Comments:
Attached to Form Schedule

Satisfied -Name: Certification/Notice

Review Status: Disapproved 10/16/2008

Comments:

Attachment:
AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE

Review Status: Disapproved 10/16/2008

SERFF Tracking Number:	*AEGX-125599266*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*38642*
Company Tracking Number:	*D491 AR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Dental*		
Project Name/Number:	*Dental/DN AR0041215C01*		

FILING ATTACHMENT

Comments:

NAIC Transmittal

Attachments:

AR - NAIC TRANSMITTAL DOC.PDF

AR - NAIC FORM FILING ATTACHMENT.PDF

AR - NAIC RATE FILING ATTACHMENT.PDF

Explanation of Variables

D491 – Individual Dental Certificate

Page 1

1. Administrative address/phone number is made variable to allow us to administer the product from other locations or to accommodate any changes in phone numbers or addresses related to moves.

Page 2

1. This page has mostly self-explanatory variables (name, address, premiums, etc.)

Page 4

1. "before/within 21 days" is used to accommodate our different administrative sites as we have different billing systems.

Page 10

1. As we use a TPA to administer claims, we keep information about the TPA, Dental Benefit Providers (DBP), variable to accommodate them. The customer will have access to up-to date claims contact information via their membership card.

Page 11

1. "Part VIII – How to Pay Your Premium" language will vary according to available payment options.

IGH002 – Dental Application

1. The variability of coverage level and dependent coverage allows us to auto populate fields and tailor applications specifically for the customer (or to allow data to be input from another source such as telemarketing)
2. Much of the rest of the application is variable to accommodate the "John Doe" nature of the applications.
3. Payment information is variable to accommodate the billing options that are available with the marketing campaign.
4. Fraud language is included so that we can use a standard application in multiple states.
5. [Your] in the signature line, can be replaced with "insured" or some other appropriate noun.
6. Administrative address/phone number is made variable to allow us to administer the product from other locations or to accommodate any changes in phone numbers or addresses related to moves.

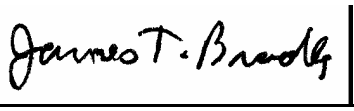
STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Stonebridge Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
D491	42.8

Signed: 

Name: James T. Bradley

Title: Assistant Secretary

Date: 04/08/08

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Stonebridge Life Insurance Company 2700 W Plano Parkway Plano TX 75075		VT		468	65021	03-0164230	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Mat Thekkil 2700 W Plano Parkway Plano TX 75075		877-527-6444 Ext. 6452	972-881-4097	mthekkil@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	D491 AR
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☒ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H10I Individual Health - Dental
10.	**Product Coding Matrix Filing Code**	H10I.000 Health - Dental
11.	**Submitted Documents**	☒ **FORMS** ☒ Policy ☒ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☒ **RATES** ☒ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☒ Certifications ☒ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	04/08/08
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	

Attached for your review and approval are forms D491, D491 O.C., IGH002 and corresponding rates. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion.

Dental Policy D491 provides benefits for preventative, basic, and major dental services. The portion of covered services will increase each Policy Year (except for preventative services which will be covered at 100% as of the effective date). Basic services will be covered at 20%, 40%, and 80% for the first, second and third Policy Years (respectively). Major services will be covered at 15%, 30%, and 50% for the first, second and third Policy Years (respectively). The Policy provides an annual maximum benefit (per insured) of $500, $750, and $1,250 for the first, second and third Policy Years (respectively). There is a $50 per year deductible per insured with a $150 maximum deductible per family.

Dental care may be obtained by Network dentists or any non-network dentist. Network dentists charge a predetermined charge (eligible expense) for dental services. Network dentists may not charge an amount that exceeds the predetermined charge. Non-network dentists may charge their prevailing charge, but benefits are based on lesser of 1) the actual charge; 2) the medium charge that half the dentists charge more and half charge less in the same geographic region; or 3) 85% of the usual and customary amount charged the same geographic region. We will pay the same coinsurance percentage of the Eligible Expense for both Network and Non-Network Dentists. There is no difference in Benefits or Deductibles between Network and non-Network Dentists.

Coverage is provided for a single adult with or without children or a married couple with or without children. There are four rate regions. Different regions of the country are assigned a rate region based on a region's prevailing charges for dental services. These products are guaranteed issue and will be mass marketed by direct response and telemarketing methods and possibly on the Internet through our website. Application IGH002 will be used to solicit this Policy.

The Policy has a Flesch Readability Score of 42.8. Microsoft Word 2003 was used to obtain these scores. Variable information is printed in red and bracketed.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print. Completed filing forms are attached.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Mat Thekkil Title Contract Analyst

Signature Mat Thekkil Date 04/08/08

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	D491 AR
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	D491 - Individual Dental Policy	D491	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
02	D491 OC - Individual Dental Outline of Coverage	D491 OC	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
03	IGH002 - Individual Dental Application	IGH002	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
04			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
05			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
06			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
07			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
08			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
09			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
10			☐ **Initial** ☐ **Revised** ☐ **Other** _____	
11			☐ **Initial** ☐ **Revised** ☐ **Other** _____	

LIFE, ACCIDENT & HEALTH, ANNUITY, CREDIT RATE FILING ATTACHMENT

Rate Filing Attachment				
This filing transmittal is part of company tracking number			D491 AR	
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing				**%**
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01	Rates - D491	D491	☒ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
02	Actuarial Memo - D491	D491	☒ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
03	AR Actuarial Exhibit C	D491	☒ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
04			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
05			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
06			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
07			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
08			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
09			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
10			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
11			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
12			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	